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The Australian Child Dental Benefits Schedule—expenditure and utilisation analysis

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Abstract

Background and objective: The Australian Child Dental Benefits Schedule (CDBS) was implemented in 2014, with the main objective to promote equity in child oral health across the country. The current CDBS is a national program for eligible children aged 0–17 years that provides up to \$1,132 (2025) in benefits for dental services over two consecutive calendar years. There is little data currently available on expenditure and utilisation trends of dental services claimed under the CDBS. The objective of this study was to identify trends in utilisation and expenditure since its implementation in 2014. **Methods:** This study was a retrospective descriptive analysis, using data from Medicare Statistics (Australian Government website) from the calendar years 2014 to 2022. Population data has been obtained from the Australian Bureau of Statistics. **Results:** Since the initiation of the CDBS until December 2022, a total of \$2.705 billion has been claimed on dental services utilised. The top three services with the highest dental expenditures were preventive (\$1.084 billion), restorative (\$ 734.3 million) and diagnostic (\$676 million). Expenditure values and utilisation trends for Preventive and Diagnostic services have increased over time while those for Restorative services have seen a gradual decline. Lower utilisation and expenditure were noted in the early childhood (0–4-year-old) population. Utilisation patterns vary across different states and territories. **Conclusion:** Although the CDBS has partially fulfilled its objective of providing oral health care to financially disadvantaged children, the long-term efficiency of this program seemed uncertain with little resolution in sight. Expenditure values are inconsistent in distribution, utilisation or uptake numbers are below predicted and barriers to access oral health care remain.

Introduction

The Australian Child Dental Benefits Schedule (CDBS) is a national program for eligible children aged 0–17 years that provides up to \$1,132 in benefits for basic dental services over two consecutive calendar years (Australian National Audit Office, 2015). It was introduced in January 2014, replacing the Medicare Teen Dental Plan and introducing a benefit cap of \$1,000. The cap has been indexed annually, with the first recorded increase occurring in 2021. That year, the cap rose to \$1,013, followed by an increase to \$1,026 in 2022. By January 2023 the cap had reached \$1,052. For the current year, 2025, the indexed cap has risen to \$1,132 (Australian Government Services Australia, 2023).

Services that receive benefit under the program include examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures. Services can be provided in a public or private setting. However, benefits are unavailable for orthodontic, cosmetic dental work or any services provided in a hospital. The CDBS services can be provided by dental practitioners, dental hygienists, dental therapists, oral health therapists and dental prosthetists who hold general or specialist registration with the Dental Board of Australia and have a Medicare provider number (Australian Government Services Australia, 2023).

The program was introduced as a long-term strategy to improve the future oral health of the Australian population by addressing the declining oral health of children with limited access to dental services due to financial limitations. It aims to improve Commonwealth expenditure on dental services for children by establishing a nationwide service system delivering a unified eligibility of care across all

states and territories in Australia. (Department of Health Report, 2019)

The CDBS is funded by the Australian Government and managed by the Department of Health and Aged Care and Services Australia. Eligibility assessment is completed by cross-matching relevant data provided by Centrelink and Department of Veteran's Affairs (DVA) with Medicare records. Once eligibility is determined, letters are mailed to parents, guardians, eligible teenagers, and Approved Care Organisations.

In 2015 it was found that less than 30% of eligible children were utilising the CDBS (Australian National Audit Office, 2015). Low utilisation patterns, and significant barriers to access by vulnerable children from remote communities, reflect this program's current inability to deliver benefits to those who most need them (Putri *et al.*, 2020; Orr *et al.*, 2021; Stormon *et al.*, 2022).

Little data currently exist on recent costs (expenditure) and utilisation trends of dental services claimed under the CDBS. The aim of this study was to analyse CDBS expenditure on services over a period of nine years, from 2014 to 2022.

Methods

This study was a retrospective analysis of Medicare data on the utilisation of the CDBS obtained from the Australian Government. Data were analysed for the period of January 2014 to December 2022, with the amount of expenditure on services provided across eight categories (Diagnostic, Preventative, Periodontic, Oral Surgery,



Endodontic, Restorative, Prosthodontics, General and Total services. Expenditure data across eight categories were analysed and compared by year. Differences in service expenditure by State/Territory were also analysed and compared. The dataset reflected all claims made under the CDBS (Medicare Statistics, Australian Government, 2023). The data included estimates of the number of CDBS patients by age group and the number of claims for dental services (for each category), provided per capita (ie. per 100,000 population). Each service has a set reimbursement price and limits on claiming frequency. The item numbers align to the Australian Dental Association (ADA) Schedule of Dental Services. The dataset provided used census-derived population denominators to calculate population-level estimates of CDBS usage (Medicare Statistics, Australian Government, 2023).

Study population

The study population included all Australian children who were eligible for the CDBS aged 0-17 years. The breakdown of the age group consisted of 0 to 4 and 5 to 17. The 0–4-year age group (pre-school age group) was presented separately, as this group had little other publicly funded access to dental care such as school dental services. The Australian Dental Association recommend that a child's first dental visit should be by the age of two years (Australian Dental Association, 2017). It is evident in studies however that few children in early childhood have access to care (Stormon *et al.*, 2022). Eligible children enrolled in the CDBS are predominantly from the 5–14-year-old age group, with 70% of the total patients enrolled from 2014 to 2018, from the 5-7-year-old and 10-17-year-old age ranges (Orr *et al.*, 2021). All item codes were obtained from the Guide to the Child Dental Benefits Schedule, Version 11, 2022. (Guide to the Child Dental Benefit Schedule, 2025).

Population data

The data for the distribution of the Australian children population were obtained from the Australian Bureau of Statistics (ABS) government website based on the Australian Census data (Australian Bureau of Statistics, 2025).

Dental services

The CDBS has a detailed list of 76 individual dental services that can be covered, including examinations, X-rays, cleaning, fissure sealing, fillings, root canals, and extractions. These 76 services are grouped into the following eight main categories: Diagnostic; Preventative; Periodontics; Oral Surgery; Endodontics; Restorative; Prosthodontics; and General services (Guide to the Child Dental Benefit Schedule, 2025). Expenditure/claims data on all services were included in the analysis of the study. When comparing expenditure /claims data across the various states and territories, only the data for Diagnostic, Preventative and Restorative services were used, as these services displayed the highest expenditures. The numbers of services other than the main three were very low (the three services analysed included more than 92% of all services).

The services included under diagnostic, preventative and restorative include the following: Diagnostic services: oral examination (011, 012), intraoral radiographs (022,025);

Preventive: removal of plaque (111), removal of calculus (114,115) topical fluoride (remineralisation or cariostatic agents) (121), Fissure/ tooth surface seal (161,162); and Restorative: one to five surfaces of metallic restoration (511-515), one to five surfaces of adhesive restoration, anterior and posterior (521-525) and (531-535). Provisional /temporary restoration (572), metal band, pins, bonding of tooth fragment, metallic preformed crown (SSC) (586,587) posts.

As periodontic (0.06%), prosthodontic (0.02%), oral surgery (3%), endodontics (0.0006%), and general services (0.72%) were relatively minor contributors to overall services, they were not analysed as separate categories when analysing data for State variations, but their data are included in total services (Guide to the Child Dental Benefit Schedule 2025).

Data analysis

All data were analysed using Microsoft Excel 2010 (Microsoft Corp, Redmond, WA, USA). The dollar amounts were provided via the Human Services website which details expenditure for all Medicare expenses (Medicare Statistics, Australian Government, 2023). The information outlined included all dollar amounts for services per calendar year, including the specific Medicare items for each state. Cost of services converted to \$ values based on CDBS benefit (Claims) amounts as per the website were obtained.

Ethical approval

All data for this study required no ethical approval, as they were from openly accessible sources. All expenditure and services data were obtained from the Medicare Statistics data, from the Australian Government Department of Human Services Website (Medicare Statistics, Australian Government, 2023).

Results

The total cost or expenditure for the first nine years of the CDBS amounted to \$2.705 billion (Table 1). Among the three most frequently utilised dental services through the CDBS since 2014, preventative services have had the highest total expenditure, while diagnostic services have had the lowest. Over the nine-year period from 2014 to 2022, \$1.083 billion was spent on preventative services,

Table 1. CDBS annual expenditure (in millions of AUD) for all services, from 2014 to 2022.

	0- 4-year-olds (millions \$AUD)	5 -17 -year-olds (millions \$AUD)	Total (millions \$AUD)
2014	11.0	276.2	287.2
2015	12.2	299.3	311.5
2016	14.2	244.0	258.2
2017	17.5	298.3	315.8
2018	18.9	314.4	333.3
2019	17.8	306.7	324.5
2020	14.5	256.4	270.9
2021	15.4	282.5	297.9
2022	16.3	289.6	305.9
Total	137.8	2567.4	2705.2
Average	15.3	285.3	300.6

\$734.3 million on restorative services, and \$676 million on diagnostic services (Table 2).

The average annual expenditure for these services under the CDBS over the nine-year study period was \$120.42 million for preventive services, \$81.58 million for restorative services, and \$75.11 million for diagnostic services. A significant drop in the annual preventive service expenditure was noted in 2020, falling to \$111.6 million, compared to \$137.6 million in 2019. However, spending increased again in subsequent years, reaching \$125.5 million in 2021 and \$131.7 million in 2022.

A similar decline in diagnostic service expenditure was observed in 2020, dropping to \$69.7 million, compared to \$83.4 million in 2019. Expenditure for diagnostic services followed an upward trend in 2021 (\$78.4 million) and 2022 (\$81.0 million). Likewise, restorative service expenditure

decreased in 2020 to \$67.8 million, compared to \$80.2 million in 2019. However, a modest increase was recorded in 2021 (\$71.4 million), continuing this amount into 2022.

Expenditure by age: From 2014 to 2022, of the total expenditure on the CDBS amount of \$2.705 billion, \$137.8 million (approximately 5.1% of total expenditure) was utilised by the 0–4-year-old population. In contrast, a significantly larger \$2.5674 billion (94.9% of total expenditure) was utilised by the 5–17-year-old population.

Among the three most utilised dental services provided for 0–4-year-olds, diagnostic services had the highest total expenditure, while restorative services had the lowest. Over the nine-year period, \$56.3 million was spent on diagnostic services through the CDBS, with an average annual expenditure of \$6.25 million. Preventive services accounted for \$49 million, averaging \$5.44 million annually. Meanwhile, total expenditure on restorative services from 2014 to 2022 was \$29.6 million, with an annual average expenditure of \$3.28 million (Figure 1). For the 5–17-year-old age group, preventive services had the highest total expenditure over the nine-year period, amounting to \$1.034 billion, followed by \$704.7 million on restorative services. Diagnostic services had the lowest expenditure in this age group, totalling \$619.7 million (Figure 2).

Tables 3 and 4 present the utilisation rates of the three most commonly accessed dental services through the CDBS, per 10,000 children in the population before and after the COVID-19 pandemic, during which lockdowns across the country prevented dental service provision. The results compare 2019 and 2021 to indicate trends from pre-pandemic and post-peak pandemic periods.

For the 0–4-year-old population, Western Australia (WA) (+274.5) and the Australian Capital Territory (ACT) (+54.6) were the only states to show an increase in service utilisation between 2019 and 2021 (Table 3). In 2019, a total

Table 2. CDBS annual expenditure (in millions of AUD) for the three most utilised services.

	Preventive (millions \$AUD)	Diagnostic (millions \$AUD)	Restorative (millions \$AUD)
2014	104.1	67.8	92
2015	120.4	75.5	90.9
2016	86.2	56.1	91.1
2017	127.6	79.8	84.4
2018	139.1	84.3	85.1
2019	137.6	83.4	80.2
2020	111.6	69.7	67.8
2021	125.5	78.4	71.4
2022	131.7	81.0	71.4
Total	1083.8	676.0	734.3
Average	120.4	75.1	81.5

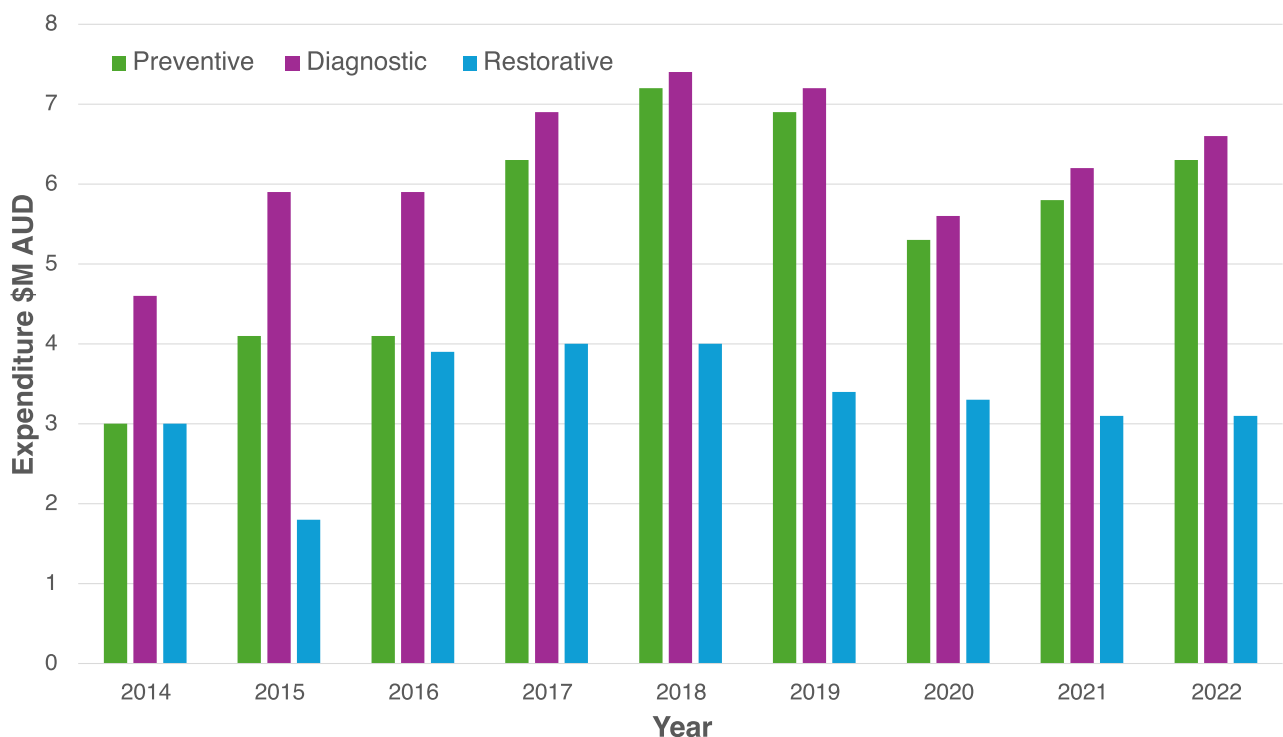


Figure 1. Total expenditure of the three most utilised dental services for ages 0–4 years from 2014 to 2022.



of 31,843 dental services were utilised by 0–4-year-olds through CDBS. By 2021, this number had decreased to 27,807, reflecting a decline of 4,035 services (Table 3).

Among the 5–17-year-old population, New South Wales (NSW) (+266) and the ACT (+25) were the only states to show an increase in total dental service utilisation from 2019 to 2021. In contrast, most states experienced a decline in total utilisation through the CDBS during 2021 (Table 4).

In 2019, 14,634 dental services were accessed by the 5–17-year-old age group through CDBS. By 2021, this number had dropped by 1,451 indicating a decline in dental service usage among this population.

Overall there was a 12% nationwide decrease in the utilisation of CDBS services in 2021 in comparison to 2019. A considerable increase in more conservative preventive service utilisation was noted during the pandemic restrictions

when the scope of dental service provision omitted aerosol-generating procedures.

Discussion

The aim of this study was to analyse CDBS expenditure and utilisation over a period of nine years, from 2014 to 2022. With the exception of 2016 (for 5-17-year-olds) and 2020 (for both age-groups), which saw slight declines in expenditure, an overall increase in preventive and diagnostic services spending has been observed nationwide. Meanwhile, expenditure on restorative services has shown a gradual decline over the years.

Over the first nine years of the CDBS program, a distinct pattern has emerged, highlighting an uneven distribution of expenditure between preschool-aged children (0–4 years) and school-aged children (5–17 years). The data

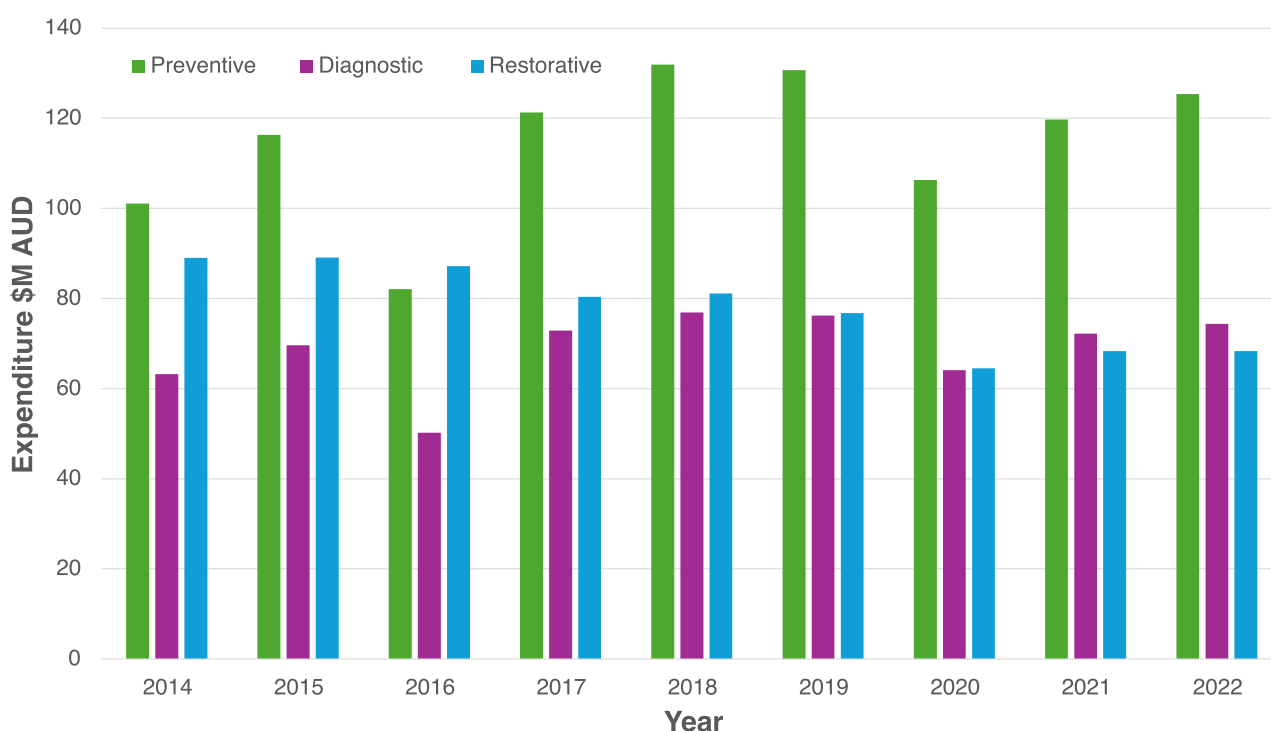


Figure 2. Total expenditure of the three most utilised dental services for ages 5-17 years from 2014 to 2022.

Table 3. Total service utilisation for the three most utilised dental services through the CDBS, per 10,000 0-4 year-old children, 2019 and 2021.

	Total Utilisation 2019 0-4 yrs	Total Utilisation 2021 0-4 yrs	Difference* 2019 vs 2021
NSW	4862.9	3324.5	1538.4 -ve
VIC	4274.1	3449.6	824.5 -ve
QLD	5358.2	5350.8	7.40 -ve
SA	5764.4	5279.2	485.20 -ve
WA	1723	1997.5	274.50 +ve
TAS	4919.4	3576.4	1343 -ve
ACT	1629.6	1684.2	54.60 +ve
NT	3311.7	3145.6	166.10 -ve
TOTAL	31843.30	27807.80	4035.50

* The results compare utilisation in 2019 and 2021 to indicate trends from pre-pandemic and post-peak pandemic periods.

Table 4. Total service utilisation for the three most utilised dental services through the CDBS, per 10,000 5-17 year-old children, 2019 and 2021.

	Total Utilisation 2019 5-17 yrs	Total Utilisation 2021 5-17 yrs	Difference* 2019 vs 2021
NSW	1064.5	1697.8	266.70 +ve
VIC	2160.3	1844.1	316.2 -ve
QLD	2338.1	2208.4	129 -ve
SA	2723.2	2490.3	232.9 -ve
WA	1070.4	1053.7	16.7 -ve
TAS	2537.5	2051.4	486.1 -ve
ACT	819.1	844.2	25.10 +ve
NT	1021.7	993.5	28.20 -ve
TOTAL	14634.80	13183.4	1451.40 -ve

* The results compare utilisation in 2019 and 2021 to indicate trends from pre-pandemic and post-peak pandemic periods.

reveals that utilisation rates and therefore expenditure for children aged 0–4 years were lower compared to those for 5–17-year-olds. It has to be acknowledged that there are more age cohorts for children aged five to seventeen, but only four for those aged 0 to four. Therefore, there's an increased possibility that 5–17-year-olds will spend more than 0–4-year-olds. Additionally, these age groups have varied dental demands. Previous analysis of utilisation of the CDBS however, confirms lower utilisation rates by younger age-groups (Putri *et al.*, 2020; Stormon *et al.*, 2022; Aminian *et al.*, 2023).

Although the CDBS is a national program, there are differences that exist at individual state and territory level which contribute to variations in uptake across all states and territories. In 2021, the Northern Territory (NT) recorded the highest percentage (25.7%) of 0–4-year-olds relative to the broader 0–17-year-old age group. However, NT reported the lowest increase in expenditure values for service utilisation. In contrast, South Australia (SA) and Queensland (QLD), which had lower recorded population proportions of 0–4-year-olds, exhibited the highest CDBS utilisation rates among this age group.

Consistent with previous research (Stormon *et al.*, 2021; Orr *et al.* 2021; Stormon *et al.* 2022), findings confirm that barriers to accessing oral healthcare in rural and remote communities can contribute to compromised service utilisation and expenditure trends in these areas. NT, home to approximately one-third of Australia's Indigenous population, and with a large proportion of 0–4-year-olds, remains the state with the lowest overall CDBS expenditure, due to low service utilisation. A similar pattern of low service utilisation was also observed in Western Australia (WA). However, WA's access to School Dental Services (SDS) has helped improve equity in children's oral healthcare, mitigating some of the disparities seen elsewhere (Lam *et al.*, 2012).

When comparing expenditure trends pre and post pandemic periods (2019 vs 2021), a 12% reduction in CDBS expenditure was noted. In a similar study by Hopcraft, a 52% decrease in the number of dental services provided through CDBS was recorded over a period of three months during the pandemic. (Hopcraft, Farmer 2021)

The primary limitations of this study stem from data collection methods and interpretation techniques. Simple mathematical calculations were applied, but more sophisticated statistical analyses could add deeper insights. Because the analysis is based on aggregated data, it is not possible to draw conclusions about individual-level characteristics that may have influenced children's oral health status, nor to assess individual patterns of service utilisation. Although this study fulfils the aim of assessing the expenditure of dental services, it has limitations on assessing the exact utilisation rates of the services by the children as the same children may have used more than one service. Lastly, this study only considers claims made under the CDBS and does not account for alternative sources of dental care that children may be accessing. This includes some State-run programs (such as the School Dental Service in WA, or Smile Squad in VIC), and treatment from private providers not claimed under the CDBS.

Considering information on costs and related effectiveness in healthcare priority setting and decision-making, is a complicated but necessary process of resource allocation. This is done in order to increase the efficiency of health system spending, whilst aiming to work towards the ideals of Universal Health Care. In 2020–21, approximately 2.6 million children aged 2 to 17 were eligible for the CDBS. Of these, only 38.7% utilised the scheme. As of June 30, 2021, the total population of children aged 2–17 in Australia was 5,075,380, with 51.1% qualifying for the CDBS. (Inquiry into the provision and access to dental services in Australia, 2023.)

Over the first nine years of its the CDBS has provided more than 3 million Australian children aged 0–17 with access to basic dental services. However, unmet dental disease remains prevalent among the Australian population. In 2022–23, children aged 5–9 years had the highest rate of preventable hospitalisations due to dental conditions (12.3 per 1,000. (Australian Institute of Health and Welfare 2024). The CDBS also shows little effect on child dental hospitalisation rates (Aminian *et al.*, 2023). Despite its availability, the scheme remains underutilised, with less than 40% of eligible children accessing the benefits and little change in the prevalence of unmet dental disease in the Australian child population (Aminian *et al.*, 2023; Do, Spencer 2017; Hopcraft, Farmer 2021; Sohn *et al.*, 2021; Peres *et al.*, 2020; Putri *et al.*, 2020).

Despite the Child Dental Benefits Schedule (CDBS) providing a comprehensive entitlement for eligible children, persistent under-utilisation indicates that financial coverage alone is insufficient to ensure equitable access to dental care. Policy responses should therefore extend beyond eligibility and focus on improving awareness among families, strengthening integration between primary medical care, public dental services, and private dental providers, and addressing geographic and workforce maldistribution. Targeted communication through schools, early-childhood services, and trusted community organisations, alongside improved referral pathways and recall systems, would support earlier and more preventive use of the scheme, particularly for children in low-income, rural, and other priority populations.

For dental practitioners, greater engagement with the CDBS has the potential to improve continuity of care, support early disease prevention, and strengthen the profession's contribution to population oral health equity. However, sustained participation will require policy settings that minimise administrative burden, provide clarity around compliance and audit processes, and ensure that remuneration and service design remain viable across diverse practice contexts, including rural and remote areas. Without concurrent measures to support practitioner participation, under-utilisation of the CDBS is likely to persist, limiting the scheme's effectiveness and contributing to avoidable oral disease and downstream demand on hospital-based services.

Conclusion

Over a nine-year period since its implementation in 2014, the CDBS has partially fulfilled its objective of providing access to dental care for financially disadvantaged children.



While expenditure has steadily increased, and more than \$2.7 billion has been spent over the first nine years of implementation, its distribution remains inconsistent and inequitable.

Author contributions

Both authors contributed to the conception of the work, the critical revision of the article, and final approval of the manuscript.

Conflict of interest statement

The authors declare no conflict of interest.

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